

STATE OF WASHINGTON



OFFICE OF  
INSURANCE COMMISSIONER

# Market Conduct Examination of Providence Health Care

1501 Fourth Avenue, Suite 500  
Seattle, Washington 98101-1621

as of November 30, 1995

---

Seattle Washington

Deborah Senn  
Insurance Commissioner  
Olympia, Washington 98504

Dear Commissioner Senn:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.020, an examination has been conducted to review the corporate affairs and market conduct activities of:

**Providence Health Care**

1501 Fourth Avenue, Suite 500

Seattle, Washington 98101-1621

Scope of Examination

The market conduct examination of Providence Health Care, henceforth referred to as the "Plan", the "Company" or, "PHC" was conducted in accordance with procedures established by the National Association of Insurance Commissioners and policies and procedures established by the Washington State Insurance Commissioner. The examination period covered January, 1, 1994 through November 30, 1995.

---

**TABLE OF CONTENTS**

PAGE	ITEM
1	Salutation
3	Examination Report Certification
4	History of the Company
4	Territory of Operations
4	Management and Control
6	Advertising
7	Agent Appointments
7	Consumer Complaints
9	Underwriting and Rate Filings
11	Provider Contracts
11	Administrative Contracts
11	Consumer Contracts
13	Claims Administration
	Summary of Examination Findings
16	Instructions

18	Recommendations
21	Acknowledgment
22	Appendix

---

## EXAMINATION REPORT CERTIFICATION

This examination was conducted in accordance with Office of the Insurance Commissioner and National Association of Insurance Commissioner's market conduct examination procedures. This examination was performed by Leslie Krier, Sally Carpenter, Sherada Washington and Fritz Denzer. Leslie Krier and Sally Carpenter also participated in the preparation of this report.

I certify that the foregoing is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of the Insurance commissioner, and that this report is true and correct to the best of my knowledge and belief.

---

Pamela Martin

Chief Market Conduct Examiner

Office of the Insurance Commissioner

State of Washington

---

## HISTORY OF THE COMPANY

Providence Health Care was originally incorporated as a not-for-profit health care services contractor (HCSC) in the State of Washington on May 27, 1992 under Corporation Number 601-391-685. The Certificate of Authority was issued April 30, 1992.

Providence Health Care contracts with hospitals, physicians and other providers of health care services; provides or arranges for health benefits through contracts with employers and other purchasers of group health care; implements delivery systems that reduce costs;

promotes preventive and personal health care education; engages in other charitable works that are consistent with the objectives of the Corporation; and, conducts its activities in compliance with The Ethical and Religious Directives for Catholic Health Facilities. Providence Health Care administers the following programs: Sound Alternatives, Small Business Plan, Healthy Options, and Business Health Networks.

June 1, 1994, Pacific Association Health (PAH) was purchased by Providence Health Care. At this point, an additional 10,000 members were added to the enrollment numbers of PHC, along with the administration of all PAH business.

See Appendix 1 for a chart of Sisters of Providence affiliated companies.

### **TERRITORY OF OPERATION**

Providence Health Care has providers in the following 21 Counties in Washington:

Clallam, Skagit, Snohomish, King, Pierce, Thurston, Mason, Kitsap, Lewis, Yakima, Chelan, Okanogan, Ferry, Stevens, Pend Oreille, Spokane, Lincoln, Adams, Grant, Walla Walla, and Douglas.

Additionally PHC operates in Kootenai County, Idaho with providers in Coeur d'Alene, Hayden Lake, and Post Falls.

### **MANAGEMENT AND CONTROL**

The business affairs of Providence Health Care are directed, managed and controlled by a Board of Directors in accordance with their Articles of Incorporation and their By-Laws. Per the Articles of Incorporation, the sole member of the Corporation is Sisters of Providence of Washington. As the sole member, Sisters of Providence has the power to alter, amend or repeal the Articles of Incorporation and the By-Laws.

---

At the April 28, 1993 Board of Directors meeting for Sisters of Providence, a resolution was adopted charging the Directors of the Good Health Plan of Washington to "exercise routine oversight and direction over Sound Health Network (a preferred provider organization), Providence Health Care, and The Good Health Plan of Washington." Since this date, it appears as though annual meetings are combined for all of the named companies. Even though the minutes from these meeting indicate that separate meetings for the PHC Board of Directors are to be held, there are no minutes or other indicators that this has taken place. It is also not possible to determine who is voting on the board

members and other issues relative to PHC, but appears as if The Good Health Plan board has taken over this responsibility.

PHC By-Laws state the requirements and duties of the Board of Directors. The Directors are to be appointed by resolution of the sole member of the corporation for a term of three years. There are to be not less than three and not more than seven members. Terms are to be staggered so that only 1/3 of the Board is appointed in any given year. Following appointment by the Board, the annual meeting of PHC is to be held, and regular meetings are to be held at least twice a year. At the meetings, a quorum of a simple majority must be present.

In reading the Board Minutes, we found the following inconsistencies with the By-Laws. A new Board has been appointed every year in July, even though the By-Laws state that they are appointed for a three year term. Appointing new board members each year does not meet the requirement of staggering board terms. In some years, it does not appear that a quorum of directors have been present. It appears that there have not been any annual meetings since 1994, but they do have combined meetings of The Good Health Plan, PHC and other affiliated companies. Finally, there does not appear to have been a quorum of PHC board members at any of the combined meetings.

It does not appear from our review that the Company is following their By-Laws concerning Board structure and annual meetings. When asked about the discrepancies, the Company was not able to produce any documentation to ensure that the By-Laws requirements had been met.

The 1995 Annual Statement filed with Office of the Insurance Commissioner identified the Officers of PHC as:

Gerald Lawrence Coe	Chief Executive Officer
Thomas James McCarthy	Vice President
Jeffrey William Rogers	Secretary
Cassandra Ann Undlin	Treasurer

---

The same document lists the Board of Directors as:

Peter William Bigelow  
David Lowell Bjornson  
Raymond Francis Crerand

**ADVERTISING**

The Company advertises by using printed advertisements in local papers, radio spots, agent sales/marketing brochures and provider materials.

The umbrella corporation, Sisters of Providence Health Plans (PHP), maintains a single advertising file for Providence Health Care and the Good Health Plan. The advertising file contained print copy of the following items: one magazine, two copies of Trend Line (a publication designed to keep employers updated on health care issues), six editions of Health Journal (member newsletter), nine tri-folded employee benefit brochures and enrollment kits (one each) for The Good Health Plan and Providence Health Care. During the examination, other advertising materials were found that had not been included in the advertising file. The Company has not retained all forms of advertisements and other communications directed at providers and the general public in their advertising file as required by WAC 284-50-200.

The name Providence Health Plans (PHP) appears to be the dominant entity on many of the advertising materials reviewed, while the name Providence Health Care appeared in secondary context. This creates the perception that the contracting entity is PHP rather than PHC. There is a great deal of redundancy in the labeling of affiliate operations and company benefit plans (Providence Health Plans, Good Health Plan, Providence Health Care, Providence Alternatives, Sound Choice, Sound Alternatives, Sound Health and Sound Health Select). OIC compliance officers have had difficulty in determining the carrier because all names appear in all materials. The OIC has discussed this problem with PHC in the past. There is concern that the average consumer may be unable to distinguish between the different affiliate organizations and benefit programs shown on enrollment materials and other advertising pieces. In 1995 the CEO and the OIC met to discuss the need to have the correct identity of the authorized entity prominently displayed in all materials. The Company was directed at that time to revise materials as necessary to ensure that the proper company was clearly identified in the materials, as required by WAC 284-50-150(1).

Two pieces of sales material reviewed quoted Company statistics, but did not state the source of the numbers used. WAC 284-50-110(3) requires this information be included in all such advertising.

---

## **AGENT APPOINTMENTS**

Business is marketed through agents and brokers who solicit employer groups, although it may be sold through a Company representative. During the examination period, agency appointments were a function of the Marketing Program Coordinator. Documentation of appointment procedures and the retention of agent and broker certificates and licenses has been inconsistent.

For the examination period, there were no appointment procedures and guidelines in place. The Company did make efforts to have agents appointed at the time a group application was received, but not prior to solicitation as required by RCW 48.44.011. Company personnel involved in direct sales activities were not appointed at the time of hire. Out of the 10 employees required to have appointments, only six had appointments prior to September 1995. All had been in sales positions prior to that date.

Nine group contract files were reviewed for active PHC agent appointments prior to solicitation. Six of nine agents were not appointed with PHC at the time they solicited the groups. Two of these were Company employees. Two agents were affiliated with brokers. Additional problems with agents identified as not appointed or late appointments are reviewed in the Underwriting and Rates section of this report.

The declined quote file was also reviewed to determine if agents were appointed in a timely fashion. Agents who had requested quotes were checked against OIC listings to determine if they were appointed with PHC. Only three of the 10 agents were appointed prior to the request for quote date. Five of 10 agents were never appointed. In two instances there was not enough information in the log to identify the agent involved to determine if they were appointed.

*Subsequent event: In 1996, the Company created written procedures for appointing agents with Good Health Plan and Providence Health Care. These procedures are written at the holding company level and are Company specific only in examples. In addition, appointments are now managed by the Regulatory Affairs Department, and procedures require appointment prior to any sales materials being distributed to new agents.*

## **CONSUMER COMPLAINTS**

The Company has established a multi-tiered complaint handling procedure that has four levels. Company complaint logs were examined and compared against consumer requests for assistance submitted to the OIC. The complaints were evaluated to determine if a profile or pattern of grievance existed. The Company has developed procedures outlining how employees are to respond to OIC inquiries and complaints as well as customer inquiries, complaints and appeals.

---

A single log is maintained for consumer complaints for Providence Health Care, The Good Health Plan, and OIC complaints. Complaints for other entities such as Sound Health are entered into the same log at times. This adds confusion to the logs and creates extra entries. The log is maintained manually and displays limited information. Because of this, it is difficult to determine which inquiries are specifically directed at PHC, the type of complaint, or the resolution.

### OIC Complaint Handling

OIC records indicate 16 consumer complaints against PHC were received by the OIC in 1995. All were reviewed as part of the examination process. Complaint subjects varied, and no trend was noted. There were three complaints related to delay of payment. This was the only category with multiple complaints.

Of the 16 OIC complaints, only three were found on Company Complaint Logs. When asked to retrieve the complaints from Company records, the Company could not locate the files.

During the examination period, complaints were handled by the department responsible for answering the complaint. They were logged into a central location, but no one person or unit was responsible for the log. All logs were maintained manually. No documentation was kept on the complaints.

Two (2) of the 16 complaints reviewed met the 15 business day response time required in WAC 284-30-650. The average response time was 35 days.

### Appeals and Grievance Procedures

The Company maintains a Medical Management Appeals (MMA) Log. There is a multi-tiered complaint handling process for both Providence Health Care and Good Health Plan. This process consists of four levels for members to appeal claim decisions.

- Level I Appeals on claims less than \$250.00.
- Level II Appeals on claims over \$250.00 and for denied Level I appeals.
- Level III CEO review when a member requests Grievance Committee review for a denied Level II claim or when disagreements occur about denials at Level II, and further discussion is required before the member is advised of the action.
- Level IV Grievance Committee hearing.

---

Complaint file records for Levels I, II and III complaints were reviewed for both GHP and PHC for January 1, 1995 through October 31, 1995.

	Total Complaints	Reversed on Appeal
Level I	205	191
Level II	110	68
Level III	84	32
Level IV	0	0

Total

399

281

Of the total complaint population, 199 or 49% of the Level I , II and III appeals were from members who did not get pre-approval for treatment. It appears that this may be a trend and may require further member and/or provider education in this area. A summary of the complaints during the examination period shows:

- 49% of Level I, II and III appeals were related to the pre-approval process.
- 74.6% (235) of Level I and II appeals resulted in reconsideration and payment of the claim in question.
- 84 appeals reached Level III.

- 36% were related to medical necessity.

- 38% of the lower level decisions were reversed resulting in payment of the claim

*Subsequent event: The Company has written policies and procedures for handling grievances and complaints. The procedure is dated 10/8/96, and establishes a centralized point of control for handling of grievances, appeals and complaints.*

## UNDERWRITING AND RATES

Agents, brokers and employer groups may call PHC for quote requests. Agents and brokers are given a manual that describes PHC's history, mission statement and product line summaries. The manual does not give agents and brokers information regarding the types of groups desired by PHC. Because of this lack of information many groups are declined because the industry is not acceptable. The agent manual reviewed contained a majority of pages labeled as "Draft". The agent manual does not appear to be a finished document, but rather one that is in process.

---

Each new business quote request is logged in a new business quote sheet the day it is received. One log is kept for both PHC and GHP. Once a group chooses a benefit package, an application is completed. If the group does not meet the underwriting guidelines for PHC, an alternative is offered through Good Health Plan or the group is declined. PHC does not write individual coverage.

Enrollment for group business is managed through the cooperative efforts of Marketing, Underwriting, Contract Services and Membership Services departments. Marketing

handles quotes, Underwriting uses census information to determinate rates, Contract Services issues the final contract for delivery and communicates new and renewing enrollment information to Membership, Customer Service, and Claims. The Membership area is responsible for coding benefits into the system.

Combined company new business quote files were reviewed. The new business quote logs were incomplete and lacking information in many fields. There were 660 quotes were received from January 1995 to October 1995. The Company declined to quote on 223 requests.

The declined quote log was reviewed for compliance with RCW 48.44.220 and RCW 48.43.035(1) which state that a health care service contractor may not deny coverage based on ethnic, religious, or national origin, or physical, mental, or sensory handicap.

A random sample of 10 decline to quote files were reviewed. Documentation in eight (8) of 10 files was inconsistent and incomplete. Only three (3) of 10 files were declined in writing. It was not possible to determine if declination letters were sent on the other seven (7).

Of the reviewed files, six (6) were declined because the industry was not acceptable, three (3) were declined because more than 10% of the population resided outside of the Company's territory of operations, and one file was declined because the employer had previously terminated with PHC and the Company declined to requote.

Four active group files were reviewed to determine if the rates quoted and the rates charged had been filed with the OIC prior to use. One (1) group was quoted an incorrect rate. The other three (3) groups were quoted and sold filed rates. For the group quoted unfiled rates, we found that base rates matched those filed with the OIC, but rating factors did not. In discussing the rating system with PHC's Analytical Services Department, the Company stated that in August 1995, they began testing a new rating model that used unfiled rates. The test continued until September 1995. When the test was completed, the Company continued to use the unfiled rates and factors in the rating model for new business quotes and renewal processing for existing groups. In addition, the Company renewed a number of groups "off-anniversary" in November 1995. These cases were renewed using the unfiled rates.

*Subsequent Event: 1996 rates and rating factors were reviewed to determine if the Company was currently using filed base rates and filed factors in the automated rating program. According to the sample group calculations, both 1996 filed rates and factors are being used in the rating system for 1996 calculations.*

---

## **PROVIDER CONTRACTS**

The majority of the provider network for Providence Health Care consists of sub-contracted Preferred Provider Networks including Sound Health network for primary and specialty providers, MCC Behavioral, Inc. network for mental health and chemical dependency treatment, and Chiropractic Network Services. The contracts between PHC and Sound Health, and between PHC and Chiropractic Network Services were filed with the OIC. However, when asked for executed copies of these agreements, the Company did not have them in their files.

PHC does maintain 13 standard provider contract forms that have been filed with the OIC and approved by the OIC. As PHC does not directly contract with any providers, there were no provider files to review.

### **ADMINISTRATIVE CONTRACTS**

There were two administrative contracts in effect as of the date of the examination. Those were between PHC and Sound Health, and between PHC and the Good Health Plan.

Both contracts contain acceptable hold harmless and insolvency language. The Sound Health contract does not contain any provisions concerning pricing. As discussed in the Claims Administration section of this report, problems have arisen in paying claims because of the length of time it takes the claims to move through the Sound Health pricing process.

*Subsequent event: The Sound Health agreement was filed with the OIC in January 1997.*

### **CONSUMER CONTRACTS**

The membership handbooks are easy to read and understand. The handbook covers who is involved in the plan, how to use the plan, and what the benefits are. The organization of the handbook has two drawbacks. First, the Definitions section is in the back of the book. The other is that while the Exclusions and Limitations are a separate item under the Schedule of Benefits, they are not mentioned in the Table of Contents and may be overlooked by members.

During the examination period, Providence Health Care filed standard forms, contracts and rates annually. Historically they have been filed in December for an effective date of January 1 of the following year. Endorsements and amendments are filed during the year as needed. Upon review of the contracts, amendments and endorsements, we found three amendments had not been filed with the OIC, but had been distributed to members.

---

As part of the examination, six (6) contracts were randomly selected to check for filed contracts, amendments and endorsements. These contracts were chosen from a list of in-force groups prepared by the Company. The group contract files contained copies of the master contracts and renewal information. We found one (1) contract that contained three (3) unfiled amendments. The amendments were part of the contract for Group SA00494, and named LIFETIME-MEM, 94PHCGMAS and LIFETIME.

*Subsequent event: A procedure dated 1/17/97 was written to establish procedures for filing of rates and forms. The procedure requires all filings to be coordinated through the Regulatory Affairs Department.*

#### Termination of Contracts for Non-Payment of Premium:

When a premium is not paid by the due date, the Company begins procedures to collect the premium. Company procedures state that on the 10th day after the due date, the Accounts Receivable Accountant (A/R A) generates a list of groups that are late paying premium. This list is broken down by Account Representative (AR), and sent to the appropriate AR. The AR has 3 days to contact the group. If they are able to contact the group, they negotiate a payment date. If the AR is unable to reach the group, the notice is returned to the A/R A to send out a late notice. If payment is not received by the negotiated payment date, the A/R A then notifies other departments that the group is late in paying their premium. It is at this point that the Claims Manager is notified to put the group on "hold".

There is no procedure established insure that providers are advised of the delinquent status of group. If a provider calls the Company for pre-authorization of treatment, they are notified of the change of status once the eligibility information is updated on the system. Other vendors, such as MCC Behavioral, are advised of eligibility status by a monthly report sent to their offices. As updates to the eligibility listings are done only on a monthly basis, the vendor and the Company may be relying on outdated information to pay claims and pre-authorize treatment.

The Company stated that it is normal for the late payment to be received within 20 days of the original due date. However, in reviewing Company records, it was found that it is not unusual for payments to lag by 30 to 60 days. At the end of 1995, 28 groups were in the 0 - 30 days late category, 10 were in the 31 - 60 days late category and 12 groups were in the over 60 days late category. The Company states that they have had only 1 group that has had to be sent to collections to receive back premium, and no groups have been canceled for non-payment of premiums. Claims received or services provided for enrollees from late paying groups are handled as if the group payment was current. Any adjustments are made when the Company determines that the group has lapsed.

---

## **CLAIM ADMINISTRATION**

Providence Health Care's claims are processed on two PC based systems. Small group claims are processed on the Eldorado System. All other claims are processed on SureCare along with the Good Health Plan claims. PHC does not have the capability to handle electronic data interface (EDI) claims, so all claims are received on paper forms. The hard copy of each claim and its backup is retained indefinitely. Claims are micro-filmed upon receipt. Claims are then batched by line of business and entered into the appropriate system. The final adjudication of a claim can occur either in the nightly system cycle or through the Company's weekly batch voucher processing system. Vouchers and advice-of-payments for capitated programs are run weekly.

The system assigns the document control number to a claim upon completion of payment and/or final adjudication. The document control number is based on the date of receipt or mail room date (MRD) and the numerical sequence of the respective claim. Claims are batched by MRD. Claims received from Sound Health (SH) contracted providers are first forwarded to Sound Health where the claim is priced, then forwarded to PHC for processing. The Company's determination of the date-of-receipt has undergone changes in criteria during 1995. Historically, the date PHC received the claim after pricing was used as the date of receipt. Current procedure is to use the Sound Health receipt date as the claim receipt date. This means that a claim could be received at PHC but never recorded until it is returned from Sound Health.

The SureCare system automatically checks enrollee eligibility, identifies duplicate services and flags user defined Common Procedural Terminology (CPT) codes for manual review. The SureCare system is capable of handling EDI linkages on a very limited basis, but modifications are needed to fully implement that process. The Company that designed the SureCare system is out of business. Vendor support to update or modify the system is not available.

The SureCare system is unable to process multiple dates of service on a claim. This means that claims with multiple dates are split and assigned numbers for each date of service. In addition, the system does not automatically accrue Coordination of Benefits (COB) savings or coordinate a single provider identification number if the provider reimbursement is paid from multiple rate schedules. To overcome the latter problem, the Company assigns multiple identification numbers to a single provider if claims for provider services must be processed against different reimbursement tables. The system has no capacity to cross reference the provider ID numbers.

---

The Eldorado system is capable of automatically checking the enrollee's eligibility. It can calculate deductibles, COB payments and COB savings. In addition, it identifies claims with duplicate services, can process multiple dates of service per claim and flags or suspends specific CPT procedure codes to allow the Medical Services staff to examine the services and ensure program benefit and medical necessity are appropriate. The system can not edit for other health insurance, bundled charges or large dollar services/claims.

Training for claim processors and examiners is conducted by section Lead individuals, supported with written procedures and is reinforced through feedback from quality assurance audits that are conducted weekly. Audits are completed on 5% of the claims processed each week.

Controls to reconcile the number of claims received vs. the number completed are manual. Management reports are used to monitor work-in-process at the employee or line-of-business level. Vouchers and advise of payment forms are run weekly through a batch cycle by line-of-business.

Utilizing a sample population extracted by Arthur Andersen, 54 claims received between 1/1/95 and 9/30/95 were independently tested. Review of the test population revealed the following information:

Average claims processing time reported on the Company's 1995 Key Business Indicator report is 16.3 days. The lag time calculated from this examination's sample population indicated the average number of days for claim turnaround was 38.5 calendar days. One reason for this difference is that the Key Business Indicator report counts time service from the date a claim is returned from SH, while our sample used the MRD. The difference represents the amount of time a claim is held at SH. There is no provision in the SH contract to specify the turnaround time for claim pricing.

Coordination of Benefits (COB) processing appears to be handled correctly if the member provides proof of payment with their claim form. However, the current procedure is to deny claims that require Coordination of Benefits when the enrollee fails to provide proof that a claim has been submitted to the primary carrier. WAC 284-51-090 and 100 require a company to pursue coordination of benefit information and if they are unable to obtain the required information in a reasonable period of time, they are required to pay as primary carrier. The current procedure violates this regulation.

Company procedure calls for duplicate claims or re-bills to be handled manually. If adjustments are required, the original claim is re-opened and re-processed. When this occurs, new information overlays old information on the system and all historical data is erased. Thus, there is no audit trail.

The Eldorado system is owned and managed by the Pacific Association. Consequently PHC's ability to implement modifications or improvements is restricted. System changes are implemented only through the consensus process and approval of all vendors in the Pacific Association.

---

*Subsequent event: In mid-1996, the Company completed a project to determine ways to expedite claims handling. The result of this project is that they have revised work flows, increased check production to 2 times per week, instituted a claim number tracking system, enforced a provision in the provider contract that requires the providers to*

*adhere to a 7 day return standard on all correspondence on claims, and established a new accounts payable holding report for review of pending claims.*

*The Company also entered into an agreement with the OIC to terminate the PAH contracts and move them to PHC products. When complete, this will eliminate the need for the Eldorado claims system. All business will be moved to a new system, AmiSys, about 7/1/97.*

---

## **PROVIDENCE HEALTH CARE**

### **SUMMARY OF EXAMINATION FINDINGS**

#### **INSTRUCTIONS**

##### **Advertising**

1. WAC 284-50-200 requires that every insurer maintain a complete file of all advertising material. The advertising file reviewed as part of this examination did not contain all forms of advertising material. Providence Health Care is instructed to comply with WAC 284-50-200. (Page 6)
2. WAC 284-50-110 requires that the source of any statistics used in advertising be included in the material. PHC is instructed to comply with this requirement in all future advertising, or reprinting of current advertising. (Page 6)
3. PHC is instructed to comply with WAC 284-50-150(1) requiring the full name of the Company to be listed on all advertising material. While the name of the parent company may be shown, the premium focus must be on the full name of the authorized carrier for the product being advertised. (Page 6)

##### **Consumer Complaints**

4. WAC 284-30-650 requires that a company must respond to all correspondence from the OIC within 15 business days. The Company is instructed to change procedures to ensure that they are in compliance with this section of the code. (Page 8)

##### **Agent Appointments**

5. RCW 48.44.011 requires that any individual or agency who solicits business on behalf of a company must be licensed with the State of Washington and appointed with the health care service contractor prior to

soliciting business. The Company is instructed to appoint agents and employed marketing representatives prior to allowing them to solicit business. (Page 7)

## **Consumer Contracts**

### **Underwriting & Rates**

6. RCW 48.44.040, WAC 284-44-130 requires Health Care Service Contractors to file all contracts and rates with the OIC prior to use. It further requires that any changes or modifications to the contract or rates be filed with the Commissioner prior to use. Three amendments were found not to have been filed with the OIC.

---

In addition, the Company created a new rating model for use by underwriters in quoting rates. The rates were used for a period of 5 months, and were never filed with the OIC. There were 36 groups quoted for PHC and Good Health Plan benefit plans using the unfiled model, two of which were sold. There were also 41 groups renewed in both companies using the unfiled rating model.

Providence Health Care is instructed to file all contracts, endorsements, riders, and rates with the Office of the Insurance Commissioner prior to offering them to the public. (Pages 10 & 12)

### **Claims Administration**

7. WAC 284-51-090 states that the Company must use all means available to them to obtain primary carrier information when they receive information that indicates coordination of benefits is involved in a claim. WAC 284-51-100 requires that a claim be paid as if the Company was the primary carrier, if primary coverage information is not available after a reasonable period of time. Current PHC procedures state that claims shall be denied when the Member does not submit the primary carrier payment information with their claim form. PHC is instructed to comply with COB regulations and cease denying claims when they are submitted without the primary carrier information. (Page 14)

---

## **RECOMMENDATIONS**

The following items were noted during the examination as either operational weaknesses or potential problems. It is therefore recommended that Providence Health Care

implement the following and take appropriate action to make improvements in these areas:

1. As of April 28, 1993, the parent company, Sisters of Providence , adopted a resolution charging Directors of Good Health Plan to oversee Providence Health Care. There was not an amendment to the PHC Bylaws to change any functions of the PHC Board or structure of the Company. The PHC Bylaws outline requirements for Board actions in several areas, including but not limited to appointment of Board Members, tenure of Board Members, quorum requirements, annual and regular meetings, and election of Officers of the Corporation. During the examination, we did not see evidence that the PHC Board was complying with these requirements. It is recommended that the PHC Board of Directors amend the Bylaws to reflect these changes. (Page 4)

2. Many of the records for Providence Health Care, Sound Health Network and Good Health Plan are intermingled. As two of these companies are separately authorized entities and the third is an unregulated Preferred Provider Organization, it is important to be able to distinguish between records for each entity. It is recommended that the Company keep separate records for each company in all phases of operation, even though the daily work is handled by the same personnel.

3. In several areas file documentation and written procedures have failed to keep up with changes within the Company. Controls are lacking to ensure that historical information, documentation and procedures are in place. It is recommended that the Company aggressively pursue measures to create written procedures for every operational area. Some of the areas found to be lacking controls are:

a. Quote logs for new, renewing and declined business. These need to be completed to ensure accuracy and consistency of the quoting process, and to have historical data available for future inquiries and quotes. (Page 9)

b. Procedures and documentation for OIC filings (rates, handbooks, group contracts, endorsements, provider contracts). This includes the need to keep historical filing documentation for all filings and to maintain separate filings for each Company. (Pages 9, 11)

c. Maintain separate complaint logs for each company. Documentation should include enough information to give a brief description of the complaint, who handled it, elapsed time from receipt to completion, and the final resolution. This information should be reviewed on a

regular basis by management, and the information used to evaluate training needs, trends and possible problem areas.  
(Page 7)

---

d. It is further recommended that procedures for each company be documented, and that each procedure contain the effective date, the procedure it replaces and the date of that procedure. A central control point should be established to ensure that procedures are distributed to all manual holders. The control point should also keep all versions of a procedure to ensure a historical file of company operations is maintained.

4. It is strongly recommended that the Company implement tighter controls on late paying groups. Providers and the members rely on accurate information from PHC concerning eligibility for services. It is important that late pay status be communicated to groups and providers immediately. Retroactive termination of a group results in provider payment being reversed and the provider seeking payment from the member. The hold harmless provisions of the provider contract will be void from the retroactive termination date. (Page 12)

5. Currently, duplicate and rebilled claims are not entered into the claims processing system, a practice that camouflages actual claim handling statistics. It is recommended that procedures be changed to accurately account for all claims received by entering all claims into the system.  
(Page 13)

6. It is recommended that PHC examine the claims flow between itself and Sound Health to improve turn around time and customer service. In addition, it is recommended that a provision be added to the contract between Sound Health and PHC to state that pricing of claims is the responsibility of Sound Health, and to state a specific turnaround time for the pricing function. (Page 13)

7. It is recommended that management pursue system enhancements and/or software tools that are designed to enhance the accuracy, consistency and cost effectiveness of paying claims. It appears that management relies heavily on employee review and intervention to identify claims that are subject to coordination of benefits and large dollar claims. There are no system edits in place to catch high utilization or unbundled procedures. Current systems and staffing in a claims intensive, production environment does not provide adequate or cost effective controls. (Page 13)

*Subsequent event: PHC is converting to a new computer system about 7/1/97 that has the ability to provide these controls.*

---

8. Currently, "Limitations and Exclusions" are listed as a sub category under the Schedule of Benefits in the member handbooks. For ease of use by enrollees, it is recommended that this section be included in the Table of Contents so that a subscriber can readily find this information if needed. (Page 12)

9. The Company needs to clarify Amedical necessity A and prior approval requirements to member. It was noted during the review of Company complaint records that 36% of Level III complaints involved a question of medical necessity. 49% of member complaints arose from members not obtaining prior approval for services, receiving non-approved services, and/or not using the required referral process. (Page 7)

---

## **ACKNOWLEDGMENT**

Acknowledgment is hereby made of the cooperation extended to the examiners by all the employees of Providence Health Care during the course of this examination.

---

## **APPENDIX 1**

## **AFFILIATED COMPANIES**

Sisters of Providence in Washington
-------------------------------------

91-725998

Sisters of Providence Health Plans in Washington

91-1317364

The Good Health Plan  
in Washington

91-1354269

Providence Health Care

91-1559981

Sound Health  
Network

(PPO)